



MEDICAL BOARD OF CALIFORNIA

Licensing Program



APPLICATION INFORMATION FOR A POSTGRADUATE TRAINING AUTHORIZATION LETTER (PTAL)

A Postgraduate Training Authorization Letter (PTAL) allows you to seek and commence ACGME accredited training in California.

MINIMUM REQUIREMENTS TO APPLY FOR A PTAL

- To be eligible for a Postgraduate Training Authorization Letter (PTAL), applicants must have received all of their medical school education from and graduated from a medical school recognized or approved by the Medical Board of California. The medical school's name must exactly match the name on the Board's list of recognized medical schools. Prior to submitting an application, please refer to the Board's Web site to verify your medical school is recognized:

http://www.mbc.ca.gov/applicant/schools_recognized.html
- Section 31(e) of the Business and Professions Code allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with the Board. A license issued by the Board may be suspended if state tax obligation is not paid. Disclosure of your United States Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c)(2)(c)) authorize collection of your social security number. An Individual Taxpayer Identification Number (ITIN) is not acceptable. *Reporting a number on your Application that is not your U.S. Social Security Number may be grounds for denial of licensure.*
- To meet the examination requirement for a PTAL, you must have taken and passed all components of USMLE Steps 1 and 2 per Section 1328 of Title 16 California Code of Regulations. Results of 75 or better are required to satisfy the examination requirement.
- Certification by the Educational Council for Foreign Medical Graduates (ECFMG) is required. To obtain further information regarding ECFMG Certification, please refer to their Web site at www.ecfm.org.

GENERAL INFORMATION

- As an applicant, you personally are responsible for all information disclosed on your Application, Forms L1A-L1F, including any responses that may have been completed on your behalf by others. An application may be denied based upon omission, falsification or misrepresentation of any item or response on the application or any attachment. The Medical Board of California considers violations of an ethical nature to be a serious breach of professional conduct.

GENERAL INFORMATION (Continued)

- **Processing Times:** Application materials are processed in the date order in which the application is received in this office. All application forms and supporting materials are stamped with the date and time received in the office. Generally, you should anticipate receiving written correspondence confirming the status of the application for licensure within 60 days of submission of the application.

- **Fingerprints:** Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. You will need to use the *Request for Live Scan Service* form that may be obtained from our Web site. Please refer to the following Web site for a listing of Live Scan facilities in California: <http://ag.ca.gov/fingerprints/publications/contact.php>

Applicants residing outside California must submit two completed fingerprint cards or have your fingerprints completed at a California Live Scan facility. Fingerprint cards will be mailed to you once the Board receives your application and appropriate processing fees. All personal data must be completed on the fingerprint cards.

Please be aware that if you have ever suffered a conviction, the record of the conviction will be reported to the Board as a result of your fingerprint inquiry. *Criminal Records Check from both the California Department of Justice and the Federal Bureau of Investigation must be received prior to the issuance of a Physician's and Surgeon's License.*

- **FCVS:** The Federation Credentials Verification Service (FCVS) is operated by the Federation of State Medical Boards of the United States, Inc. The Medical Board of California (Board) offers this link to FCVS as a convenience to our applicants. You may learn more about FCVS at: <http://www.fsmb.org/fcvs.html>.

The Board does not mandate that you use the FCVS. FCVS is NOT a requirement for filing a Physician's and Surgeon's Application. You will be required to complete the Board's application and provide all necessary supporting documentation. As part of your application, you may request FCVS to submit directly to our Board your *Medical Professional Information Profile*. We will review the information provided along with our application and determine on an individual basis the items that we will accept from FCVS.

- **Convictions:** Note that convictions adjudicated in juvenile courts or convictions two years or older under Health and Safety Code sections 11357(b), (c), (d), (e) or section 11360(b) need not be reported. Convictions expunged or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law **MUST** be disclosed. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application. The Board receives information regarding convictions that have been expunged.
- **Grounds for Denial:** Each applicant's credentials for licensure in California are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant's act of dishonesty, unprofessional conduct, conviction of a crime, discipline of another state license or inability to practice medicine safely.
- **Due Diligence:** Pursuant to Section 1306 of Title 16 California Code of Regulations, an application shall be deemed abandoned if an applicant fails to complete the application process within 365 days from the date of written notification from the Board of the documents needed to complete the application.

APPLICATION INFORMATION

Listed below are the minimum application and supporting materials required for an international medical school graduate to obtain a Postgraduate Training Authorization Letter (PTAL). This list is not all-inclusive as additional items may be necessary based on responses provided on your *Application* or information obtained from other entities. Please refer to the *PTAL Checklist* and our Web site for further detailed information regarding each requirement.

- Application for Postgraduate Training Authorization Letter, Forms L1A-L1F
- Copy of Live Scan Request Form (CA resident) or Two Fingerprint Cards (Outside CA)
- Application fees of \$491.00 or copy of online payment receipt
- Current Curriculum Vitae (CV)
- Timeline of Activities Form
- ECFMG Certification Status Report
- Official USMLE Step 1 and Step 2 scores
- Certificate of Medical Education, Form L2
- Official medical school transcript
- Certified copy of medical diploma
- Official English translation (if applicable) – Refer to the *Translation Information* sheet
- Certificate of Completion of ACGME/RCPSC Postgraduate Training, Form L3A-L3B, (if applicable)
- Certificate of Clinical Training, Form L5
- Certificate of Individual Clinical Clerkship Training, Form L6 (if applicable)
- Explanation to Question #__ Form (if applicable)

Examination Documentation

- Official Examination and Board Action History Report to verify passing scores on all components of USMLE Step 1 and Step 2. ***The Federation of State Medical Boards (FSMB) must submit official examination scores directly to the Board to be acceptable.***
- A Certification Status Report from the Educational Council for Foreign Medical Graduates (ECFMG) is required to verify your certification is valid. ***The ECFMG must mail the Certification Status Report directly to the Board to be acceptable.***

Medical Education Documentation

- Transcripts, diplomas and any other academic documents prepared in a language other than English will need to be accompanied by a certified English translation. Please refer to the *Translation of International Academic Credentials* information sheet for details regarding acceptable English translations. ***The certified translation must be mailed directly from the translator to the Board to be acceptable.***
- A Certificate of Medical Education, Form L2, is required from each medical school of attendance. The Form L2 will need to be completed, signed and dated by the school official and affixed with the official medical school seal. Any fields or questions left unanswered will require completion of a new form. ***The Form L2 must be mailed directly from the medical school to the Board to be acceptable.***

Medical Education Documentation (continued)

- An original official medical school transcript and translation if not in English, prepared on university letterhead affixed with the signature of the dean or registrar and the medical school seal, documenting all of the basic science and clinical courses completed during the medical curriculum is required. A transcript is required for each medical school attended. ***The transcript must be mailed directly from the medical school to the Board to be acceptable.***
- Certified copy of your medical school diploma. The certified copy must have the original signature of the dean or registrar of the medical school; be affixed with the official school seal; and include a statement attesting that the copy is a true and correct copy of the original. ***The certified copy of your diploma must be mailed directly from the medical school to the Board to be acceptable.***
- A Certificate of Clinical Training, Form L5, is required to report all undergraduate clinical clerkships. The Form L5 will need to be completed, signed and dated by the school official and affixed with the official medical school seal. You may print or copy as many L5 Forms as necessary to provide a complete breakdown of your undergraduate clinical training. ***The Form(s) L5 must be mailed directly from the medical school to the Board to be acceptable.***

For your information, the pertinent portions of Section 2089.5 of the Business and Professions Code require:

“(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.

(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.”

Please refer to our Web site at to obtain a complete copy of Section 2089.5.

- Certificate of Individual Clinical Clerkship Training, Form L6, is required for each undergraduate clinical clerkship completed *outside* of the primary teaching hospital of the medical school of attendance. The L6 Form must be submitted to the hospital where the clerkship was completed and the current program director or clinical instructor must verify completion of the clerkship. ***The completed Form(s) L6 must be submitted directly from the facility to the Board to be acceptable.***

If the hospital where an undergraduate clinical rotation was completed is now closed, the medical school may provide a certified copy of the student evaluation form that was initially completed by the sponsoring hospital. The copy must be affixed with the medical school seal and signature of the dean certifying it is a true copy of the original document.

For your information, only undergraduate clinical clerkships meeting the criteria specified in Section 2089.5 of the Business and Professions Code will be used to satisfy the required 72 weeks of clinical clerkships.

Postgraduate Training Documentation (if applicable)

- A Certificate of Completion of ACGME/RSPSC Postgraduate Training, Form L3A-L3B, is required to verify the completion of each year of accredited training.

A Form L3A-L3B must be submitted to each postgraduate training program for completion. The current program director must provide all of the required information and responses on the form, sign and date the form, and affix the hospital seal. If a hospital seal is not available, the program director must sign in the presence of a notary and the notary seal must be affixed. A “yes” response to any of the Unusual Circumstances questions on Form L3A requires a signed and dated letter of explanation from the current program director. ***The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable. Any letters of explanation must be provided on program letterhead, signed by the program director and mailed directly to the Board.***

Please be advised, Section 2066 of the Business and Professions Code allows graduates of international medical schools to engage in three years of ACGME accredited postgraduate training without a license. In calculating the maximum three years of training, the Board includes all approved training completed in the U.S. and Canada whether or not any credit was granted. At the end of the three-year period, you must be licensed or all clinical activities in California facilities must cease.

Other Items .

- Please submit a current Curriculum Vitae (CV) with your application.
- Complete the *Timeline of Activities* form to document professional and non-professional activities from the graduation of medical school to the beginning of ACGME or RCPSC accredited postgraduate training. Please use as many forms as necessary to provide a complete timeline of activities. Please submit the completed form(s) to the Board with your application.
- The *Explanation to Application Question #__ Form* may be used to provide a detailed written explanation for a “yes” response to a question on the application. The form may be obtained from our Web site. The Board will also accept a signed and dated letter of explanation.



MEDICAL BOARD OF CALIFORNIA

Licensing Program



Postgraduate Training Authorization Letter (PTAL) Checklist

(Do Not Submit - Keep For Your Records)

Application, Fees and Fingerprints		
<input type="checkbox"/> Application Fee	<p>A minimum of \$491.00 is required to submit an application for a PTAL. Refer to the <i>Fee Schedule</i> for details.</p>	Notes/Date Sent:
<input type="checkbox"/> Application For Physician's and Surgeon's License, Forms L1A-L1F	<p>Complete all fields, answer all questions and have the application notarized.</p>	Notes/Date Sent:
<p>Fingerprints:</p> <input type="checkbox"/> Live Scan Form (CA Only) or Two (2) Fingerprint Cards	<p>Applicants who reside in California must complete the electronic <i>Live Scan</i> fingerprint process. A copy of the completed <i>Request for Live Scan Service</i> form must be submitted with your application. The form may be obtained from the Board's Web site.</p> <p>Applicants residing outside of California may submit two completed fingerprint cards or visit a California Live Scan facility. <i>Fingerprint cards will be mailed to you once the Board receives your application and appropriate processing fees.</i> All personal data must be completed on the fingerprint cards.</p>	Notes/Date Sent:
<input type="checkbox"/> Timeline of Activities	<p>A complete timeline from the graduation of medical school to the present is required. Provide the Board with a written chronological description of all your professional and non-professional activities with no gaps over three months.</p> <p>If you have completed any externships, observerships, or volunteer activities in California, please include a detailed description of your duties and responsibilities along with the location and name of the supervising physician.</p> <p>Mail your signed and dated <i>Timeline of Activities</i> form directly to the Board.</p>	Notes/Date Sent:

Postgraduate Training Authorization Letter (PTAL) Checklist

Examinations		
<input type="checkbox"/> Educational Commission for Foreign Medical Graduates (ECFMG) Certification Status Report	<i>Request a Certification Status Report be sent directly from ECFMG to the Board to verify your certification is valid. You may obtain further information from their Web site at www.ecfm.org.</i>	Notes/Date Requested:
<input type="checkbox"/> Official Examination Scores from the Federation of State Medical Boards (FSMB)	Official Examination and Board Action History Report to verify passing scores on USMLE Step 1 and Step 2. Official scores may be requested from their Web site at www.fsmb.org . <i>The scores are electronically sent directly from FSMB to the Board.</i>	Notes/Date Requested:
Medical School Documentation		
<input type="checkbox"/> Certificate of Medical Education, Form L2	Complete the applicant information at the top of the form and mail it to your medical school for completion. A completed Form L2 is required for each medical school attended. <u><i>The completed form must be mailed directly from the medical school to the Board to be acceptable.</i></u>	Notes/Date Requested:
<input type="checkbox"/> Official Medical School Transcript	An official medical school transcript is required from <u>each</u> medical school attended. <u><i>The transcript must be mailed directly from the medical school to the Board to be acceptable.</i></u>	Notes/Date Requested:
<input type="checkbox"/> Certified Copy of Medical School Diploma	A certified copy of your medical school diploma is required. The certified copy must include a statement verifying authenticity, the signature of the dean or registrar and the official medical school seal must be affixed. <u><i>The certified copy of the medical school diploma must be submitted directly from the medical school to the Board to be acceptable.</i></u>	Notes/Date Requested:
<input type="checkbox"/> Certified English Translations (if applicable)	Certified English translations are required for all academic documents that are not prepared in the English language. Refer to the <i>Translation of International Academic Credentials</i> for details regarding acceptable translations. <u><i>The certified translation must be mailed directly to the Board to be acceptable.</i></u>	Notes/Date Requested:

Postgraduate Training Authorization Letter (PTAL) Checklist

Medical School Documentation (continued)		
<input type="checkbox"/> Certificate of Clinical Training, Form L5	<p>Complete the applicant information at the top of the form and mail it to your medical school for completion. You may use as many forms as necessary to provide a complete breakdown of your undergraduate clinical training. <u>The completed Form(s) L5 must be mailed directly from the medical school to the Board to be acceptable.</u></p> <p><i>Refer to Section 2089.5 and 2089.7 of the Business and Professions Code for clinical training requirements.</i></p>	Notes/Date Requested:
<input type="checkbox"/> Certificate of Individual Clinical Clerkship Training, Form L6 (if applicable)	<p>Complete the applicant information at the top of the form and mail it to the hospital where you completed the clerkship. The current program director or clinical instructor must complete the form. <u>The completed Form L6 must be mailed directly from the facility to the Board to be acceptable.</u></p> <p>Please note: A Form L6 is required for <u>each</u> clinical rotation that was completed outside of the primary teaching hospital of your medical school.</p>	Notes/Date Requested:
Other Items		
<input type="checkbox"/> Curriculum Vitae (CV)	<p>Please submit a signed and dated current CV with your Application.</p>	Notes/Date Sent:
<input type="checkbox"/> Explanation to Application Question #_____ (if applicable)	<p>This form may be used to provide a detailed written explanation for a “yes” response to a question on the Application. Please use a separate page for each positive response. The form may be obtained from our Web site.</p>	Notes/Date Sent:



MEDICAL BOARD OF CALIFORNIA

Licensing Program



FEE SCHEDULE

Application for Physician's and Surgeon's License or Postgraduate Training Authorization Letter (PTAL)

Part 1: Application Fee			
The application fee includes a required fingerprint processing fee. Please note, the application will not be reviewed until the required application fee is received.			
Total Non-Refundable Application Fee	Required	→	\$ 491.00
Part 2: License Fee			
<p>License fees are required prior to issuance of your medical license. To reduce delays in issuing a license, you may submit the application and license fees together.</p> <p>Initial License Fee (\$808.00) or Reduced Initial License Fee (\$416.50) – If you currently are enrolled in an ACGME/RCPSC accredited training program, you may be eligible for the reduced initial licensing fee. To verify your enrollment, you will need to submit a Certificate of Current Postgraduate Training, Form L4.</p> <p>NOTE: PTAL applicants are not required to submit the initial license fees until all licensing requirements have been met.</p>			
Initial License Fee or Reduced Initial License Fee	Required Prior to Licensure	\$808.00 or \$416.50	\$
Part 3: Voluntary Fee			
<p>You may contribute \$25 to provide training for family physicians and other primary care providers who will serve medically underserved rural and inner city Californians, refugees, the frail elderly and people with AIDS.</p> <p>This program was established as a result of legislation authored by the late Dr. William Filante and is supported by the California Medical Association, the California Academy of Family Physicians, and other leading health care organizations. Dr. Filante's bill authorized this State's Office of Statewide Health Planning and Development (OSHPD) to accept contributions from certain foundations, health maintenance organizations, health insurers and entities to augment these primary care training programs, which are located in hospitals throughout California.</p>			
Family Physician Training Fee	Voluntary	\$25.00 (minimum)	\$
Part 4: Total Amount			\$
<p>Certified Check, Cashier's Check, Money Order, or Personal Check made payable to: MEDICAL BOARD OF CALIFORNIA</p> <p>or</p> <p>At time of initial application, you may make a one-time online payment at: http://www.dca.ca.gov/proflc/medicalbd.shtml</p>			



MEDICAL BOARD OF CALIFORNIA Licensing Program



TRANSLATION OF INTERNATIONAL ACADEMIC CREDENTIALS

For the Board to fairly evaluate compliance with California requirements, any applicant with non-English, international academic credentials must provide certified translations of those original transcripts and academic documents. These must be original, official certified translations. **Photocopies are not acceptable.** When requesting official transcripts and academic documents, an applicant whose education was completed at an institution in a bilingual country, where English is one of the official languages, may be able to avoid the necessity of arranging for a translation by asking the school to generate an English-language version of the transcript.

Applicants may also request their medical school to provide original, official, literal word-for-word, certified translations of their official transcripts and academic documents. The Board will consider medical school translations prepared on the official school letterhead with the translator's original declaration, and the translator's signature and title.

- **Each translator must provide an original signed declaration with each translation attesting to his/her fluency in the particular language and certifying under penalty of perjury that the translation is complete and accurate to the best of the translator's ability and knowledge. Each translation must be accompanied by a copy of the corresponding non-English document. The official certified translation must be mailed directly from the translator to the Board to be acceptable.**
- **Translators who prepare translations may not be related to an applicant by blood, marriage, or adoption. Translations that are signed on behalf of the official translator are not acceptable; the translator who prepares the translation must provide the signed declaration. Translations without an official letterhead will not be accepted.**

The Board recommends, but does not require, that applicants with non-English academic credentials use one of the following sources for translation:

1. **Translator accredited by the American Translators Association (ATA):** The ATA accredits individual translators by examination. Although accreditation is available only to individuals, ATA membership includes not only individuals but companies that employ accredited translators. The translator who prepares the translation must sign the translation and declaration in the presence of a Notary Public, unless the translation is a service provided by a known translation agency which affixes the document with its own official seal. ATA membership includes accredited translators residing in the U.S., Canada, Mexico, and overseas. Although the ATA does not make referrals, a listing of accredited translators and member companies is available through its Web site at www.atanet.org. The ATA may be reached by phone at 703-683-6100 or by e-mail at ata@atanet.org.
2. **Certified or registered court interpreter:** Some state court systems offer examinations for certification or registration of court interpreters. In California, the Judicial Council is charged with these functions. Information on court interpreters is available through the Judicial Council at 415-865-4200. General information is available via its Web site, www.courtinfo.ca.gov. The Judicial Council has contracted with Cooperative Personnel Services (CPS) for examination and certification of Certified Administrative Hearing and Medical Interpreters. A master list of these interpreters is available at the CPS Web site, www.courts.ca.gov/3796.htm. The court interpreter must sign the translation and declaration in the presence of a Notary Public. Applicants residing outside California but within the United States may call the National Center for State Courts at 800-616-6164 for information on certification and registration of interpreters in other states.

Other authorized translators the Board will consider include: (1) a commercial translation agency with its own business letterhead and official agency seal or notary public seal; (2) the Chairman of the Department of Foreign or Classical Languages of a U.S. university (prepared on original school letterhead); or (3) a consulate of the U.S. Embassy with bilingual translators available.

NOTE: The official certified translation must be mailed directly from the translator to the Board to be acceptable.



EXPLANATION TO APPLICATION QUESTION # _____

Type or Print Legibly

NAME:	Last	First	Middle
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation	
____ / ____ / _____	XXX - XX - _____		

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

SIGNATURE: _____ DATE: _____

07A-100 Revised 8/2013



MEDICAL BOARD OF CALIFORNIA

Licensing Program



TIMELINE OF ACTIVITIES

A complete timeline of activities from graduation of medical school to present is required. Provide the Board with a written chronological description of all your professional and non-professional activities. Please include a detailed description of your duties and responsibilities for any externship, observership, or volunteer activity in California. Dates shall be reported in chronological order in month/year (mm/yyyy) format. *Please use as many forms as necessary to provide a complete timeline of activities.*

Type or Print Legibly

APPLICANT INFORMATION

NAME:		Last	First	Middle
Date of Birth (mm/dd/yyyy)		U.S. Social Security Number		Medical School of Graduation
___ / ___ / ___		XXX - XX - ___		

Start Date	End Date	Location (Provide Facility Name, Address, and Supervisor, if applicable)	Activities	MBC Use Only
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>

Signature: _____

Date: _____



MEDICAL BOARD OF CALIFORNIA

Licensing Program



APPLICATION

(Please Check All That Apply)

- ☐ Physician's and Surgeon's License
☐ Postgraduate Training Authorization Letter (PTAL)
☐ Update Application: ATS # _____
☐ Limited Practice License

(Please Check One)

- ☐ U.S. or Canadian Medical School Graduate
☐ International Medical School Graduate

Type or Print Legibly				PERSONAL INFORMATION				MBC Use Only	
1. Legal Name		Last		First		Middle			
2. Other Names/Alias									
3. United States Social Security Number		4. Gender							
						<input type="checkbox"/> Male <input type="checkbox"/> Female		Personal Information	
5. Date of Birth (mm/dd/yyyy)				6. Place of Birth (City, State/Country)					
7. Public/Mailing Address		Mailing Address (30 characters maximum per line, including spaces)						Exams	
If you are using a P.O. Box please include a confidential street address on a separate sheet of paper. The address of record will be posted on the Medical Board's Web site once you have obtained a license.		Mailing Address continued (30 characters maximum per line, including spaces)							
		City		State/Province		Zip/Postal Code			
8. Telephone Numbers		Home # ()		Work # ()		Cell # ()		Prev License	
9. E-mail Address								<input type="checkbox"/>	
10. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	
11. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	
EXAMINATIONS									
12. Have you ever been found to have engaged in irregular behavior during an examination?						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	
13. Have you ever been subject to an investigation by an examination entity?						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	
14. Are you certified by the Educational Commission for Foreign Medical Graduates? If yes, please provide the Certificate Issue Date: _____						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	
15. List all of the following examinations you have taken: USMLE, FLEX, NBME, LMCC and/or STATE BOARDS (Use the Addendum to Question #15 Form if additional space is needed)									
Examination		Date (mm/yyyy)		Result (Pass/Fail)					
Cashiering Use Only						School Code		L1A	

MEDICAL EDUCATION				
NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code (effective 1/2013). To view the Board's list, please refer to our Web site at: http://www.mbc.ca.gov/applicant/schools_recognized.html .				
16. List each medical school that you have attended.				
Medical School Name	Mailing Address	Attendance Dates (mm/dd/yyyy)		
		Start		<input type="checkbox"/> L2 <input type="checkbox"/> Trans <input type="checkbox"/> School Code
		End		
		Start		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		End		
		Start		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		End		
17. School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)		
				Diploma <input type="checkbox"/>
UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL				
18. Did you ever take a leave of absence during medical school?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
19. Were you ever placed on probation?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
20. Were you ever disciplined or placed under investigation?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
21. Were any negative reports ever filed by your instructors?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
22. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING				
23. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? List every program in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted. (Use the Addendum to Question #23 Form if additional space is needed)			(If NO please skip to question # 33) <input type="checkbox"/> Yes <input type="checkbox"/> No	Postgraduate Training <input type="checkbox"/>
Facility Name	City, State/Province	Specialty	Training Dates (mm/dd/yyyy)	
			Start	
			End	
			Start	
			End	
			Start	
			End	
			Start	
			End	
APPLICANT: (Print Name)		DATE OF BIRTH: (mm/dd/yyyy)		

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UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING					MBC Use Only
24. Have you ever received partial or no credit for a postgraduate training program?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
25. Have you ever taken a leave of absence or break from your training?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
26. Have you ever been terminated, dismissed or expelled from a program?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
27. Have you ever resigned from a program?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
28. Were you ever placed on probation for any reason?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
29. Were you ever disciplined or placed under investigation?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
30. Were any incident reports ever filed by instructors?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
31. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
MEDICAL LICENSE					
33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province? List medical license information below. It is not necessary to list temporary, training, or provisional licenses. (Use the Addendum to Question #33 Form if additional space is needed)				<input type="checkbox"/> Yes <input type="checkbox"/> No	License <input type="checkbox"/>
State/Province	License Number	Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Dates of Practice (mm/yyyy to mm/yyyy)	
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
ABMS CERTIFICATION					
34. Are you currently certified by a Member Board of the American Board of Medical Specialties?				<input type="checkbox"/> Yes <input type="checkbox"/> No	ABMS <input type="checkbox"/>
Member Board		Certificate Number	Expiration Date (mm/yyyy)		
35. Has your certification ever been suspended or revoked?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
36. Is there any action currently pending against you?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
APPLICANT: (Print Name)			DATE OF BIRTH: (mm/dd/yyyy)		L1C

DEA CERTIFICATION			MBC Use Only DEA <input type="checkbox"/>
37. Are you currently registered with the Drug Enforcement Agency (DEA)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
DEA Number	State of Issue	Expiration Date (mm/yyyy)	<input type="checkbox"/>
38. Have your DEA privileges ever been denied, suspended, restricted, or terminated?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
39. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
MALPRACTICE HISTORY			Malpractice History <input type="checkbox"/>
40. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
41. Has a judgment or arbitration ever been awarded in the amount of \$30,000 or more?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
DISCIPLINARY HISTORY			Disciplinary History <input type="checkbox"/>
These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state or territory, Canadian province, or foreign country.			
42. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
43. Have you ever been denied a license to practice medicine?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
44. Is any denial pending against you?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
45. Have you ever had any license to practice medicine subjected to any disciplinary action?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
46. Is any disciplinary action pending against any of your licenses to practice medicine?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
47. Have you ever surrendered a license to practice medicine?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
48. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
49. Have you ever had any license to practice medicine subjected to any action including, <i>but not limited to</i> , informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
50. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
51. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
52. Is any disciplinary action pending against your hospital or staff privileges?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
53. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
54. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
APPLICANT: (Print Name)		DATE OF BIRTH: (mm/dd/yyyy)	L1D

A “yes” response to questions 38-54 requires a signed and dated written explanation.

CRIMINAL RECORD HISTORY		MBC Use Only
<p>Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.</p> <p>For each conviction disclosed, you must submit certified copies of the arresting agency report, certified copies of the court documents, including a plea form and court docket, and a signed and dated descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.</p>		
<p>55. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country?</p> <p><i>This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<p>56. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>57. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<p>58. Are you a registered sex offender?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
PRACTICE IMPAIRMENT OR LIMITATIONS		
<p>If you give an affirmative answer to any of the questions below, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are eligible for licensure. Please note that a Limited Practice License may be available. Please refer to the <i>Application Information for a Limited Practice License</i> for further information.</p>		
<p>59. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<p>60. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<p>61. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<p>62. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<p>63. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<p>64. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
<p>APPLICANT: (Print Name)</p>	<p>DATE OF BIRTH: (mm/dd/yyyy)</p>	L1E

A "yes" response to questions 55-64 requires a signed and dated written explanation.

PHOTOGRAPH

Photograph

Affix a 2" X 2" Photo Here

**Photo Must Be Recent and
Must Be of your Head and
Shoulder Areas Only**

**Altered Photographs
are NOT Acceptable**

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

MBC
Use Only

Photograph



Applicant
Name & DOB



DECLARATION

The applicant, _____, _____,
Please print full name (First, Middle, Last) Date of Birth (mm/dd/yyyy)

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

SIGNATURE: _____ DATE: _____

Applicant
Signature
& Date



NOTARY SECTION

SIGNATURE OF APPLICANT: _____
(DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY – Please sign full name)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20____,

by, _____ proved to me on the basis of satisfactory evidence
(Print applicant's name)

to be the person who appeared before me.

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

Applicant
Signature



Applicant
Name &
Notary Date



Notary
Signature
& Seal



L1F



MEDICAL BOARD OF CALIFORNIA

Licensing Program



CERTIFICATE OF MEDICAL EDUCATION

Check one: ☐ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

Type or Print Legibly			MBC Use Only																																				
APPLICANT INFORMATION																																							
NAME: Last First Middle																																							
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation																																					
___/___/___	XXX - XX - ___																																						
MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE																																							
Name of Medical School			Medical School Information <input type="checkbox"/>																																				
State/Province/Country			<input type="checkbox"/>																																				
Did the applicant complete an English Language program?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																																				
<p>The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____ years of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2). The standard duration of the curriculum at this institution is _____ years.</p> <table style="width: 100%; font-size: small;"> <tr> <td>Anatomy</td> <td>Ophthalmology</td> <td>Neurology</td> <td>Pediatrics</td> </tr> <tr> <td>Otolaryngology</td> <td>Dermatology</td> <td>Alcoholism and Chemical Dependency</td> <td>Pharmacology</td> </tr> <tr> <td>Obstetrics and Gynecology</td> <td>Embryology</td> <td>Preventative Medicine, including Nutrition</td> <td>Anesthesia</td> </tr> <tr> <td>Radiology, including Radiation Safety</td> <td>Histology</td> <td>Physical Medicine</td> <td>Spousal Partner Abuse Detection & Treatment*</td> </tr> <tr> <td>Tropical Medicine</td> <td>Human Sexuality</td> <td>Therapeutics</td> <td>Family Medicine**</td> </tr> <tr> <td>Physiology</td> <td>Medicine</td> <td>Neuroanatomy</td> <td>Pain Management and End-of-Life-Care***</td> </tr> <tr> <td>Biochemistry</td> <td>Surgery, including Orthopedic Surgery</td> <td>Child Abuse Detection and Treatment</td> <td></td> </tr> <tr> <td>Pathology, Bacteriology, and Immunology</td> <td>Urology</td> <td>Geriatric Medicine</td> <td></td> </tr> <tr> <td></td> <td>Psychiatry</td> <td></td> <td></td> </tr> </table> <p>* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994 ** ONLY applicable to medical students who graduated from medical school on or after June 30, 1999 *** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000</p>			Anatomy	Ophthalmology	Neurology	Pediatrics	Otolaryngology	Dermatology	Alcoholism and Chemical Dependency	Pharmacology	Obstetrics and Gynecology	Embryology	Preventative Medicine, including Nutrition	Anesthesia	Radiology, including Radiation Safety	Histology	Physical Medicine	Spousal Partner Abuse Detection & Treatment*	Tropical Medicine	Human Sexuality	Therapeutics	Family Medicine**	Physiology	Medicine	Neuroanatomy	Pain Management and End-of-Life-Care***	Biochemistry	Surgery, including Orthopedic Surgery	Child Abuse Detection and Treatment		Pathology, Bacteriology, and Immunology	Urology	Geriatric Medicine			Psychiatry			<input type="checkbox"/>
Anatomy	Ophthalmology	Neurology	Pediatrics																																				
Otolaryngology	Dermatology	Alcoholism and Chemical Dependency	Pharmacology																																				
Obstetrics and Gynecology	Embryology	Preventative Medicine, including Nutrition	Anesthesia																																				
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Pathology, Bacteriology, and Immunology	Urology	Geriatric Medicine																																					
	Psychiatry																																						
Date the applicant enrolled in medical school:		___/___/___	Dates of Attendance <input type="checkbox"/>																																				
Date the applicant was issued the diploma of Bachelor/Doctor of Medicine:		___/___/___	<input type="checkbox"/>																																				
Date the applicant withdrew from medical school (if applicable):		___/___/___	<input type="checkbox"/>																																				
UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL																																							
Any "Yes" response below requires a signed and dated letter of explanation by school official.																																							
1. Did this applicant ever take a leave of absence from his/her medical education?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																																				
2. Was this applicant ever placed on probation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																																				
3. Was this applicant ever disciplined or placed under investigation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																																				
4. Were any negative reports regarding this applicant ever filed by instructors?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																																				
5. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>																																				
MEDICAL SCHOOL OFFICIAL CERTIFICATION																																							
AFFIX MEDICAL SCHOOL SEAL	I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.		Signature & Seal <input type="checkbox"/>																																				
	PRINTED NAME OF SCHOOL OFFICIAL	TITLE OF SCHOOL OFFICIAL																																					
	SIGNATURE OF SCHOOL OFFICIAL	DATE																																					
	<p>Attention Medical School: THE PERSON WHO SIGNS THIS FORM <u>MAY</u> NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.</p>																																						

L2

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.



MEDICAL BOARD OF CALIFORNIA

Licensing Program



CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

Check one: ☐ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

Type or Print Legibly				APPLICANT INFORMATION		MBC Use Only	
NAME:		Last	First	Middle		Personal Data <input type="checkbox"/>	
Date of Birth (mm/dd/yyyy)		U.S. Social Security Number		Medical School of Graduation			
___/___/___		XXX - XX - ____					
PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION							
ATTENTION PROGRAM DIRECTOR: <u>Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure.</u> Completion of this form will certify that the applicant referenced above has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state. <i>The completed form must be mailed directly from the program to the Board.</i>							
Facility Name						<input type="checkbox"/>	
Facility Address						<input type="checkbox"/>	
Specialty		ACGME 10-digit Program # http://www.acgme.org/adspublic		_____		<input type="checkbox"/> <input type="checkbox"/>	
Dates of Training (mm/dd/yyyy)		Start Date: ___/___/___		End Date (or anticipated completion date): ___/___/___		<input type="checkbox"/> <input type="checkbox"/>	
UNUSUAL CIRCUMSTANCES							
1. Did the applicant receive partial or no credit for any postgraduate training year?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
2. Did the applicant ever take a leave of absence or break from his/her training?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
3. Was the applicant ever terminated, dismissed or expelled?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
4. Did the applicant ever resign?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
5. Was the applicant ever placed on probation?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
6. Was the applicant ever disciplined or placed under investigation?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
7. Were any incident reports regarding this applicant ever filed by instructors?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
8. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
9. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>
Program Director: Please provide a signed and dated letter of explanation for any "yes" response to questions # 1-9. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.						L3A	

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete **four months** of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.

10. Did the applicant named on the L3A form complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC?

☐ Yes ☐ No

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable.

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

PRINTED NAME OF PROGRAM DIRECTOR

Email Address

SIGNATURE OF PROGRAM DIRECTOR
(Signature Stamp Is Not Acceptable)

DATE

Phone Number

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____
(Please sign full name in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20____,

by, _____ proved to me on the basis of satisfactory evidence
(Print program director's name)

to be the person who appeared before me.

SIGNATURE OF NOTARY PUBLIC

HOSPITAL or NOTARY SEAL

MBC
Use Only

General
Medicine

Program
Director's
Signature &
Date

Program
Director's
Signature

Notary
Signature &
Seal

Hospital
Seal

L3B

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.





MEDICAL BOARD OF CALIFORNIA

Licensing Program



Certificate of Individual Clinical Clerkship Training

This form is required of international medical school graduates who completed any clinical training outside of the primary teaching hospital of their medical school. A separate form is to be used for each clinical clerkship.

Type or Print Legibly			APPLICANT INFORMATION		MBC Use Only	
NAME: Last First Middle						Personal Data <input type="checkbox"/>
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation				
PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR TO COMPLETE CLERKSHIP INFORMATION					Program Verified <input type="checkbox"/>	
Facility Name		Facility Address				
Clinical Specialty		Dates of Completion (mm/dd/yyyy)				
		Start Date: ___/___/___ End Date: ___/___/___				
This facility is formally affiliated or has a formal contract of affiliation with a U.S., Canadian, or International Medical School.				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of the U.S., Canadian, or International Medical School. (If affiliated)						
This facility does have an ACGME-accredited residency training program.				<input type="checkbox"/> Yes <input type="checkbox"/> No		
ACGME 10-digit program # (http://www.acgme.org/adspublic):			Specialty:			
OFFICIAL CERTIFICATION						
I certify that I am the program director or clinical instructor and that the applicant named above satisfactorily completed the above named clinical clerkship and I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.						
PRINT NAME OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR			Email Address		Signature & Date <input type="checkbox"/>	
SIGNATURE OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR			Phone Number			
(Signature Stamp Is Not Acceptable)						
ATTENTION: THE PERSON WHO SIGNS THIS FORM <u>MAY NOT</u> BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director or clinical instructor may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.						
NOTE: If a hospital seal is not available, the program director or clinical instructor shall also sign in the section below in the presence of a notary public.						
Signature of Program Director or Clinical Instructor: _____					Signature <input type="checkbox"/>	
State of _____						
County of _____						
Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20____,						
by, _____ proved to me on the basis of satisfactory evidence						
(Printed name of Program Director or Clinical Instructor)					Notary Signature & Seal <input type="checkbox"/>	
to be the person who appeared before me.						
SIGNATURE OF NOTARY PUBLIC					Hospital Seal <input type="checkbox"/>	
<div style="border: 2px solid black; width: 300px; height: 80px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> HOSPITAL or NOTARY SEAL </div>						
L6						

NOTE: The completed form must be mailed directly from the facility to the Board to be acceptable.